A READINESS TO CHANGE APPROACH TO PREVENTING PTSD TREATMENT FAILURE

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INTRODUCTION

The effectiveness of treatment for combat-related posttraumatic stress disorder (PTSD) has recently been called into question, at least for therapy as delivered in Veterans Administration (VA) programs (Fontana & Rosenheck, 1997; Schnurr et al., 2003). Treatment failure has long been a concern for clinicians working with individuals with PTSD, particularly Vietnam veterans who continue to seek treatment more than 30 years after their combat experiences. This chapter offers a new perspective on PTSD treatment that: (a) explains why patients may not respond to our attempts to help them eliminate their symptoms and (b) describes both general and specific approaches to improving patient response to treatment.

BASES FOR APPLYING A READINESS TO CHANGE MODEL TO PTSD TREATMENT

Why Do Treatments Fail?

There are numerous current conceptualizations of why PTSD treatment failure occurs, particularly for patients with long-standing symptoms. Generally, these theories tend not to focus on treatment methods or

therapists as being at fault, but point to patient characteristics as the culprit in an unsuccessful treatment attempt. One common attribution made for treatment failure, especially when a patient has not been cooperative or compliant with treatment recommendations, is that the patient is "not ready for treatment." This implies that a trait of stubbornness or lack of insight is causing the patient to be noncompliant. Another attribution for treatment failure is that the patient's PTSD is "chronic," which seems to suggest that the disorder's resistance to treatment increases with the length of time the patient has the disorder, for reasons not clearly specified. This has become more popular as biological theories of chronic PTSD have come into vogue, and researchers in this area claim to have found permanent damage in hormonal or neuronal systems that control threat reactions and memory. These biological theories, though they have merit, cannot conclude that physiological damage causes symptoms or treatment resistance due to the correlative nature of their methods. Damage to biological systems may not be a necessary or sufficient factor for PTSD, and changes in biological systems may reflect a learned pattern of overreaction to threat arising from traumatic experiences. We posit therefore that there is still a need for examining psychological factors as important contributors to development of PTSD and symptom response to treatment.

Help Me Stop Being Angry, and Don't You Think the World is Full of Dangerous, Hostile, and Provocative People?

Our clinical experience with veterans in an inpatient VA PTSD treatment program revealed that patients often questioned the need to change their defensive approach to life, including hyperalertness to danger, social isolation, frequent anger, and mistrust of others. We witnessed therapists (including ourselves) sometimes debating with patients about the best way to handle situations involving social interactions with family, friends, and strangers. It became apparent that PTSD may mean something different for therapists and patients, or that a patient's view of what the problem is may be different from that of the therapists. We do not mean here that patients question whether or not they have PTSD, because most patients willingly accept the diagnosis. Rather, patients and therapists may have different conceptions about the presence or severity of specific PTSD symptoms or comorbid problems.

Patients may report, for example, that they have violent outbursts when in traffic or when dealing with unhelpful salespeople. Although

patients may later regret angry episodes, discussion of their thoughts occurring in those situations often reveals their view that they get angry because the world is populated by people who are careless, dangerous, hostile, and provocative. The connection between their responses and their personal trauma history is that their experiences have taught them that it is necessary to take a protective and defensive approach to daily life. In other words, these patients do not share the therapist's belief that PTSD-related coping responses are overreactions based on earlier life events.

Why Are You Ruining My Beautiful Treatment Plan? The Readiness to Change Model

If patients are not convinced of the need to change certain PTSD symptoms and trauma-based coping responses, what happens in treatment when patients don't do what therapists want them to? Certainly some therapists react with surprise and frustration when patients don't follow carefully crafted treatment plans or question their validity. These patients often are labeled as "resistant" or "not ready for treatment" and confrontation of the patients by treatment staff often results. If patients do not acquiesce or comply with demands for change, they may be discharged or referred elsewhere.

New approaches to treatment-resistant patients have been implemented in other areas, such as alcoholism treatment, where similar patient problems are common. The best developed theoretical work on readiness to change is the Transtheoretical Model (Prochaska & DiClemente, 1983). The model has most often been applied to smoking and substance abuse (Prochaska, DiClemente, & Norcross, 1992) but has been extended to a variety of other patient populations (Rosen, 2000). The Transtheoretical Model assumes that behavioral change and response to treatment are a function of modifiable beliefs about the need to change and not personality traits of denial or negative attitude. The Stages of Change component of the model describes five stages associated with different beliefs about the need to change and actions toward change. These stages include a lack of awareness that a problem exists (Precontemplation), ambivalence about the need to change (Contemplation), initial steps toward change (Preparation), engagement in efforts to change (Action), and maintaining change (Maintenance). A key assumption in the Stages of Change is that different psychoeducational or therapeutic techniques are needed at each stage to help individuals resolve questions about the need or ability to change that behavior and move to the next stage. Readiness

to change variables have been found to predict psychotherapy dropout (Brogan, Prochaska, & Prochaska, 1999; Smith, Subich, & Kalodner, 1995) and substance use (Belding, Iguchi, & Lamb, 1997; Heather, Rollnick, & Bell, 1993). Among trauma victims, researchers have applied the Transtheoretical Model to readiness for change in adult survivors of child abuse (Koraleski & Larson, 1997) and battered women (Feuer, Meade, Milstead, & Resick, 1999; Wells, 1998).

Concurrent with this theoretical work has been Miller's development of clinical interventions that enhance individuals' readiness to change and facilitate movement through the Stages of Change (Miller & Rollnick, 2002). Developed in response to confrontation-based approaches to alcohol problems, Motivational Interviewing encompasses both general style and specific methods for addressing patients who are apparently unaware or ambivalent about the need to change problematic behaviors. The general therapeutic approach is nonconfrontational and objective, relying heavily on reflective listening. Specific techniques for facilitating problem acknowledgment include norm comparison, decision balance, the development of discrepancy between values and behavior, and ambivalence amplification. Motivation enhancement interventions based on Miller's Motivational Interviewing approach have been found to be effective in modifying beliefs about the need to change and facilitating change for a variety of behaviors (Bien, Miller, & Tonigan, 1993). For example, such approaches have been effective in reducing HIV risk behaviors (Carey et al., 1997) and alcohol use by college students (Borsani & Carey, 2000), problem drinkers (Miller, Benefield, & Tonigan, 1993), and alcoholics high in anger (Project Match Research Group, 1998).

Finally, Newman (1994) has provided an insightful approach to conducting a functional analysis of patient resistance in cognitive therapy. He emphasizes that client behavior labeled as resistance is understandable in the context of an individual's developmental history and current environment, and often serves a protective or fear avoidance function.

Evidence for Ambivalence or Lack of Awareness About the Need to Change PTSD Symptoms Among Veterans

What evidence is there that veterans with PTSD are unaware of or ambivalent about the need to change particular symptoms and modes of responding? Only two studies have directly addressed this issue. Murphy et al. (in press) collected data on beliefs about the need to change PTSD symptoms and other problems from 243 male veterans in an inpatient VA

PTSD treatment program over an 18-month period. Patients were asked to list on a form any problems they classified as "Might Haves," defined as "Problems I'm not sure I have" or "Problems others have told me I have, but I disagree." Patients were asked to list separately any problems they were sure that they had. These open-ended responses were coded into various PTSD symptoms and other problem categories. For example, patient reports of "flying off the handle," "rage," and "aggression" were all categorized as Anger; "distrust" and "suspicious" were classified under the Trust category. Participants classified a wide range of PTSD symptoms and related behaviors as "Might Have" problems, with the highest percentage of patients (48%) classifying Anger as a "Might Have." Approximately one third of the patients labeled Isolation, Depressive Symptoms, Trust, and Health as a "Might Have," and about one fourth reported Conflict Resolution, Alcohol, Communication, Relationship/Intimacy, Restricted Range of Affect, and Drugs as "Might Have" problems. Other types of PTSD-Related problems, for example, Hypervigilance, were reported as "Might Haves" by 15 to 21% of the patients. Reexperiencing problems were rarely identified as "Might Haves."

A study by Rosen et al. (2001) sought to determine if there were distinct subgroups of combat PTSD patients that differed in their readiness to change alcohol or anger problems. Male combat veterans (N = 102) entering a PTSD rehabilitation program completed the University of Rhode Island Change Assessment (URICA) and process of change questionnaires based on the Transtheoretical Model (Prochaska et al., 1992). Separate assessments were made for alcohol abuse and anger control. Patients varied in their readiness to address these two problems, and could be categorized into four motivational subtypes consistent with the Transtheoretical Model. Strikingly, 35% of the PTSD inpatients with severe anger were in Precontemplation or Contemplation stage for anger as a problem. Motivation to change alcohol problems was independent of that for anger. For both alcohol abuse and anger management, patients in the Action/Maintenance stage for that problem reported more frequent use of change strategies than did patients in the Precontemplation stage.

Problem Endorsement Versus Belief About the Need to Change: Two Different Things Entirely

Patients may not always appear to lack awareness of the need to change PTSD-related behaviors and beliefs. On symptom checklists and in structured interviews, patients will frequently endorse a wide variety of PTSD

symptoms. Clinicians can be misled into thinking that patients are sure that they need to change these symptoms or PTSD-based beliefs, yet patients' true beliefs about the need to change these problems can contradict their symptom report. How can this occur? Generally, patients may see certain problematic behaviors or beliefs as being different from a symptom as typically labeled. Some patients, for example, will endorse hypervigilance as a symptom because they always feel "on guard" or hyperalert to danger, but will not see related behaviors or beliefs as problematic. They may see problems such as mistrust of others, isolation, needing to be in control, or owning multiple weapons as reasonable ways of responding to potential threat, and not as a psychiatric symptom.

Patients may also believe that they have a problem but not believe that it is truly their problem. To illustrate, patients will usually endorse anger as a PTSD symptom, and frequently regret times when they lost control of their temper. Yet some of the same patients will state that if other people or certain situations did not provoke them, they would not have an anger problem. When describing instances of anger outbursts, they will justify their response (e.g., "The other driver was careless and was going to get someone killed" in cases of road rage). In general, the issue is one of responsibility for the problem that usually involves externalizing the symptomatic reaction or cause of the symptom. Thus, patients may report that they have an anger problem, yet be unconvinced of the need to change. Some patients will even use their combat experience as a justification of their response. Patients may report, for example, that they are highly mistrustful of others, yet defend this PTSD symptom by stating, "I've seen what happens when you depend on other people," or "Combat showed me reality—life is dangerous, you've got to protect yourself from other people." Similarly, we have seen patients endorse anger as a problem, yet later report that they disagree with others' complaints that they are short-tempered or irritable, again often justifying the behavior with statements like "You've got to be hard on people because they just won't do things right."

Finally, the reality of the compensation system often causes patients to report PTSD symptoms that they really do not think are problematic or wish to change. Because most patients are concerned that service-connected disability payments may be put at risk if their symptom report does not continue to confirm their diagnosis, there is a natural bias toward overendorsement of symptoms on checklists and structured interviews. Open-ended assessment of what problems trouble patients, and their understanding of PTSD symptoms they have endorsed, may be a

better method for revealing what they believe they need to change in order to improve their lives.

WHY WOULD SOMEONE NOT BE READY TO CHANGE?

One of the less well-developed areas in the readiness to change literature has been explanation of how individuals with serious problems can be unaware of the need to change. Miller's work certainly examines some of these factors, because they are related to the targets of particular techniques. What is needed, and what we present here, is a fuller discussion of what we see as the reasons why individuals may not be convinced of the need to change behaviors, beliefs, and coping styles that are maladaptive. Consistent with the work of Miller, Prochaska, DiClemente, Newman, and others, we posit that most of these reasons or causative factors are products of normal cognitive processes and background familial, social, and cultural events and influences, and are not particularly pathological, in that they may apply to anyone regardless of the presence of a mental disorder.

Cognitive Roadblocks to Admitting a Problem to Myself

There are numerous reasons why an individual might not be willing to consider the need to change that are not specific to PTSD or psychopathology in general. One set of these reasons relates to why someone might be unwilling to admit a problem to oneself.

What's normal for our patients (and for us)? The role of perceived norms. What determines our sense that our behavior or beliefs need change? One factor may be our consideration of where our responses to stress, social interactions (e.g., intimacy), or daily life challenges fit in a normal or average range of behavior. From an early age, we begin to view as "normal" that which happens in our family, regardless of the dysfunctional nature of our family's behaviors or beliefs about people and methods for coping with life's challenges. This can apply to family norms for behavior itself, like expressing feelings and needs, asking for help, drinking alcohol, or using aggression in intimate relationships and child rearing. In addition, we can learn early on in our families what is "normal" for the severity and types of behavioral consequences, such as doing time

in jail or family disruption due to alcohol. Constant exposure to these experiences in the family does not leave a child with a clear understanding of societal norms for problem behaviors or their consequences. The main point here is that when experiencing difficulties later in life, an individual lacks a sense that "something is wrong," that is, something is occurring that is out of the range of what happens to the average person.

For veterans, an additional factor hindering consideration of the need to change problematic behaviors is that an additional set of norms can be learned in the military and in the combat zone. We have frequently heard veterans say that they were trained that it was shameful and "unmanly" to ask others for help or show certain emotions such as fear. Norms for survival in combat can include suppression of grief or fear (especially by the use of anger), avoidance of close attachment to others, a life-or-death sense of control, and refusal to allow the decisions of others to impact one's life. For many soldiers, these behaviors and beliefs can be a normal and understandable part of military life, especially in the war zone. As with childhood experiences, adult exposure to civilian norms for at least some individuals does not always erase the sense of what are personally acceptable behaviors. And for many veterans seeking treatment, their post–military life involved dangerous jobs (e.g., police work) or outlaw lifestyles (such as being in gangs or dealing drugs) that reinforced their notions of normative behavior.

Internal stereotypes. Consideration of the presence of a problem can elicit "internal stereotypes," or incorrect perceptions of what it means to have a particular disorder. Alcoholics may not want to admit to a drinking problem or seek treatment because their stereotypes of people so labeled involve images of the town drunk, a homeless person, or some other extreme and inaccurate depiction (Cunningham, Sobell, & Chow, 1993; Cunningham, Sobell, Sobell, & Gaskin, 1994). This can be particularly true for a problem drinker who maintains a job and family life, and whose mental picture of an alcoholic includes social isolation and unemployment. These persons may not see themselves as similar to those stereotypes, and thus they cannot have the same problem, or they find thought of having the same problem as those individuals to be so aversive that they will avoid taking on the same label. Sometimes these stereotypes come from more personal experiences, such as having a parent with a particular problem. In these cases in particular, if the parent elicited shame, anger, or disgust due to their behavior, the person can be particularly averse to admitting to a similar problem. Similarly, veterans may

have internal stereotypes of psychiatric patients that involve inaccurate images of a "raving lunatic" or the "crazy Vietnam vet" who needs a straitjacket and cannot function in society. Therefore, their negative reaction to suggestions that they seek psychiatric care for PTSD-related behaviors is understandable. Early exposure to media depiction of people with mental disorders can contribute to these stereotypes. For many veterans who came home from Vietnam in the late '60s and were experiencing difficulties adjusting to civilian life, their only exposure to what psychiatric care involved came from the movie *One Flew Over the Cuckoo's Nest,* which portrayed not only very disturbed individuals but horrific conditions of confinement and care.

Avoidance of negative emotions elicited by problem recognition. Often people do not acknowledge a problem because they are avoiding some type of fear (Newman, 1994). This includes including fear of incapacity or death elicited by recognition of a mental or physical disorder. For example, medical patients with cardiac problems or diabetes may not follow treatment regimens or make lifestyle changes because compliance means acceptance of the presence of disease or condition, which can elicit fears of dying, becoming disabled, or being reliant on others. Also, problem recognition can be hindered by a feeling of being overwhelmed by problems already acknowledged, which may be particularly true for persons with multiple ongoing difficulties. For many individuals, adding another problem to their list of things to deal with is simply seen as another opportunity for failure, and so they avoid consideration of additional problems to recognize. Other negative emotions that can be elicited by problem recognition include feeling weak or stupid due to an inability to handle or solve problems on one's own, and feeling ashamed or "crazy" if there is a potential mental health problem.

The pros and cons of change. Another nonpathological cognitive process that guides decision-making about the need for change is the relative balance of the advantages or "payoffs" of behavior and the disadvantages or negative consequences. An individual's engagement in a behavior despite negative consequences is often more understandable to both patient and therapist when there is clear understanding of the balance of subjective advantages and disadvantages of that behavior. Since immediate consequences of behavior have more reinforcement value than long-term consequences, it is also critical to understand that patients will persist in behaviors that have short-term rewards despite long-term negative conse-

quences (e.g., alcohol consumption or isolation to avoid conflict). This may be particularly important to motivation enhancement approaches since patients may be unaware of how this weighing of pros and cons controls behavior.

Cognitive Roadblocks to Admitting a Problem to Others

Problem acknowledgment can be limited by factors related to the social context of admitting a problem. Individuals may fear various consequences of publicly acknowledging a problem, including rejection or other negative reactions by family members, partners, or friends. They may be reluctant to admit the need to change to others to avoid shame or being judged as "damaged," weak, sick, or crazy.

External Roadblocks to Considering the Need to Change

There are sometimes realistic environmental or social factors that make it difficult for an individual to consider the need to change or could get in the way of change (Miller & Rollnick, 2002). Patients who rely on disability compensation, for example, may fear that any responsibility-taking implied by problem acknowledgment could cause agencies to attribute responsibility for ongoing difficulties to the patient and not to life circumstances or continued illness. They therefore may be concerned that problem acknowledgment may put their compensation at risk of termination. Further, problem acknowledgment and its consequences, including the need for treatment, may cause family disruption or other unwanted life changes. Other realistic concerns that patients may have related to publicly admitting a problem involve issues of confidentiality, job security, and employer reactions, as well as a host of other environmental disincentives to change (Newman, 1994).

Why PTSD Patients May Be Ambivalent About Changing

"The average guy is stupid": Beliefs about trauma-based coping. In addition to perceived norms and the other roadblocks previously discussed, other factors that limit consideration of the need to change problematic behaviors can include the apparent functionality of maladaptive behavior, which

can be maintained by short-term positive consequences and a perceived lack of options for responding due to a lack of models for adaptive coping. This may be particularly true for trauma victims, for whom Criterion C and D trauma symptoms "feel right" (i.e., appropriate responses regarding safety and minimization of fear, for example, hypervigilance and avoidance of trauma reminders). We have heard many PTSD veterans who acknowledge that their own behavior is not typical of most people defend their coping style by saying "The average guy is stupid" with respect to levels of danger inherent in daily life.

Another factor that may hinder PTSD patients' recognition of problems is guilt. For those veterans who feel guilty that they survived combat when many of their friends did not, any problem solving related to their difficulties in life brings up guilty feelings of not deserving to feel good or live a satisfying life. This may be further compounded by guilt over postwar substance use and relationship problems. They therefore may hesitate to actively pursue therapeutic tasks such as consideration of previously unacknowledged problems that may be causing them difficulties. This can be particularly true for Vietnam veterans, for whom problem acknowledgment can mean facing an enormous sense of loss and guilt over almost 40 years of personal difficulties and mistreatment of loved ones that they have staved off by the belief that their behavior was justified.

Low Self-Efficacy as a Roadblock to Acknowledging the Need to Change

Taking action to address a problem after acknowledging the need to change may at least partly depend on an individual's self-efficacy (Bandura, 1989), or belief that change is possible and will have a positive outcome. Low self-efficacy about the ability to change can result from a number of factors, including lack of understanding about how therapy works (Newman, 1994; Zweben & Li, 1981). The public is rarely exposed to appropriate examples of good therapists, and popular media presentations of therapy often depict inept or unethical therapists (e.g., *The Sopranos* TV series or the film *Analyze This*). Good therapy involves time spent on goal setting, development of a therapeutic relationship using reflective listening, and skills training, which do not lend themselves to creation of dramatic scenes or talk-show segments where self-change gurus emphasize charismatic persuasion and confrontational interpretations of guests' misbehaviors and problems.

Two other factors related to low self-efficacy about change are the need for social support in facilitating change and resource availability. Social support is a critical predictor of therapeutic success (e.g., alcohol treatment; Sobell, Sobell, Toneatto, & Leo, 1993). The importance of this factor may be underestimated by therapists and patients. Some patients believe they must "go it alone." They understandably have anxiety about their ability to change. In addition, patients may have real roadblocks to implementing change, which are not acknowledged by therapists and are sometimes mistaken for resistance or denial. As Miller and Rollnick (2002) have emphasized, patients must have the resources needed for change available to them. Any single working parent, for example, would understand the importance of finances, time, energy, and day care in attempting to engage fully in treatment for a disorder.

A STAGES OF CHANGE MODEL FOR PREVENTING PTSD TREATMENT FAILURE

Treatment Outcome Implications of a Stages of Change Approach to PTSD

A readiness to change conceptualization of PTSD treatment failure posits that treatment outcome depends primarily on matching interventions to the patient's Stage of Change regarding particular symptoms. Treatment failure can then be explained as being due to therapist or treatment program mismatching interventions to a patient's Stage of Change, which can be caused by misreading or ignoring the patient's Stage of Change for specific problems. Mismatch can result in patients exiting treatment unconvinced that their particular ways of coping and thinking are maladaptive (e.g., hypervigilance, isolation, anger). When this occurs, patients don't see a need to use new coping skills, thus continuing or returning to trauma-based coping. The end result is poor posttreatment adjustment and a return of symptoms.

Assessing Stage of Change

Although there are psychometrically validated instruments for assessing Stage of Change for specific problems (e.g., alcohol, smoking, spouse abuse), methods for assessing Stage of Change for PTSD symptoms and

related problems are still being developed. One general approach to assessing readiness to change is the University of Rhode Island Change Assessment scale (URICA; McConnaughy, et al., 1983). The URICA contains 32 items assessing beliefs about the need to change and action toward change, each rated on a 5-point scale, from 1, strongly disagree, to 5, strongly agree. Items include "I guess I have faults, but there is nothing I need to change" (Precontemplation), "It might be worthwhile to work on my problem" (Contemplation), "I am really working hard to change" (Action), and "I'm here to prevent myself from having a relapse of my problem" (Maintenance). The instructions ask the patients to respond to the items in terms of whatever problem is listed in a space on the top of the form by the clinician or researcher. The URICA generates continuous scores on four scales related to the Stages of Change: Precontemplation (don't see a problem), Contemplation (thinking about changing), Action (making changes), and Maintenance (concerned about avoiding relapse).

Support for the reliability and validity of the URICA questionnaire in assessing readiness to change a wide variety of problems has been obtained (Carney & Kivlahan, 1995; DiClemente & Hughes, 1990; Greenstein, Franklin, & McGuffin, 1999; McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, et al., 1983). With respect to PTSD-related problems, the URICA has been used to assess Stages of Change for posttraumatic stress in general from sexual abuse (Koraleski & Larson, 1997), and for specific problems of anger and alcohol use among combat veterans in PTSD treatment (Rosen et al., 2001).

Another approach has been used by Murphy and colleagues (Murphy, Rosen, Cameron, & Thompson, 2002) to identify problems for which patients may be in Precontemplation or Contemplation stage as a way to identify targets for a motivation enhancement intervention, the PTSD Motivation Enhancement (PTSD ME) Group described toward the end of this chapter. A key part of the group is having patients generate a list of behaviors or beliefs that might be a problem for them. Patients fill out a worksheet (PTSD ME Group Form No. 1), which is divided into three columns: "Definitely Have," "Might Have," or "Definitely Don't Have." The "Might Have" column is further divided into two categories: "A Problem You Have Wondered If You Have" and "A Problem Others Say You Have (But You Disagree)." We have defined "Might Have" problems in these two ways to elicit not only problem areas that they have considered as possibly needing change, that is, on which they are in Contemplation Stage, but also problems that they might be unaware of or unwilling

to change, that is, Precontemplation Stage. The goal is for patients to eventually sort items listed under "Might Have" into "Definitely Have" or "Definitely Don't Have." Also in development is a checklist version of the PTSD ME Group Form No. 1, called the PTSD Readiness to Change Problem Checklist, in which specific PTSD symptoms and related problems are listed for which patients are asked to check which of the following categories the problem falls under for them: (a) A Problem You Definitely Have, (b) A Problem You "Might Have:" A Problem You Have Wondered If You Have, (c) A Problem You "Might Have": A Problem Others Say You Have (But You Disagree), and (d) A Problem You Definitely Don't Have. Psychometric validation of these instruments, which have been used extensively in clinical trials of the PTSD ME Group, is ongoing.

PREVENTING PTSD TREATMENT FAILURE: A PRACTICAL MODEL BASED ON THE STAGES OF CHANGE

In this section we present a model for preventing PTSD treatment failure that describes specific assessment and intervention techniques appropriate for patients at various Stages of Change regarding PTSD-related symptoms and problems. Before describing this model, we would like to briefly note the importance of general therapeutic style in facilitating patient movement through the Stages of Change. The reader is referred to Miller and Rollnick (2002), who describe in detail the response style and tactics that motivate patient change most effectively. An objective, nonconfrontational stance is critical, and Miller and Rollnick describe key skills and techniques that are part of this stance, including reflective listening, avoiding argumentation, rolling with resistance, highlighting discrepancies between patient behavior and goals and values, and supporting self-efficacy. These and other techniques presented by Miller and Rollnick are essential ingredients to successful implementation of the model for preventing PTSD treatment failure outlined here.

The key assumption in this approach to preventing PTSD treatment failure is that ignoring or mismatching interventions to a patient's Stage of Change for important symptoms causes problems in patient engagement in treatment and poor posttreatment outcome. This mishandling of patients in terms of their Stage of Change can impact their beliefs about the relevance of treatment components as well as their posttreatment functioning. For each Stage of Change, the following model describes

signs that a mismatch is occurring between the stage and therapy interventions, assessment strategies, and intervention recommendations. The model uses an understanding of the reasons why patients do not recognize the need to change as a basis for recommendations for assessment and intervention. For each stage, use of the structured measures for assessing Stage of Change described above will be useful, although we also suggest additional open-ended questions that are stage-specific.

Precontemplation Stage

In Precontemplation stage, a patient does not believe they have a particular PTSD-related problem (e.g., anger, alcohol, or isolation) when in reality they do. We have found it helpful to conceptualize a patient's cognitive state at each of the Stages of Change in terms of a question in the patient's mind that needs to be answered before the patient can move to the next stage. For Precontemplation, the goal of the therapist is to help the patient answer the question, "What problem?" The cause of poor treatment engagement or outcome at this stage is that therapists assume that the patient is convinced of the need to change regarding a problem (or problems) that seems obvious to everyone else, including the therapist. Acting on this incorrect assumption, therapists often begin interventions for the problem (e.g., skills training), or use argumentation, reason, and listing of negative consequences the patient has experienced in an attempt to persuade the patient of the need to change. These approaches are unlikely to be effective and will have the effect of distancing and discouraging the patient.

Precontemplation stage: Signs of stage-by-intervention mismatch. These signs include the patient missing appointments, not doing therapy tasks, attempting to reduce but not eliminate behavior, minimizing or externalizing responsibility for changing, and blaming others for causing consequences to their behavior (e.g., "The police didn't need to arrest me for the anger-related incident"). Also, the patient doesn't see similarity between themselves and others with the same problems (e.g., "I'm not like those vets who go off"). Additional signs include the therapist feeling frustrated, and using the term "not ready for treatment" with respect to the patient.

Precontemplation stage: Assessment. Based on the analysis of why someone might not acknowledge the need to change, assessing a patient's readiness

to change at this stage should include an empathic discussion of the patient's opinion about why others see need for change. Also, it would help clarify what might be getting in the way of the patient acknowledging a problem by asking what it would mean to the patient to have that problem.

Precontemplation stage: Intervention. Helping patients answer the question "What problem?" primarily involves education about PTSD in general or the nature of a particular symptom. For example, what exactly hyperarousal is and how it can manifest itself in daily life and social interactions. As part of this education, it is important to translate clinical symptom labels into concrete descriptions of behavior. Again using hyperarousal as an example, it may be useful to talk about irritability, short-temperedness, or as the patients often state, "intolerance" of other people's shortcomings in social, family, and work settings (e.g., blowing up in response to slow or inefficient salespeople). It may also be helpful to talk to the patient about how internal stereotypes, cognitive distortions (e.g., "If I have one more problem, it will be a disaster"), and other internal roadblocks prevent people from recognizing or acknowledging problems. The goal of this approach at this stage is only to support the patient in acknowledging that there may be a problem, at which point the patient would be in Contemplation stage.

Contemplation Stage

In Contemplation stage, the patient is unsure or ambivalent about the need to change, with their question being "Do I need to change?" Difficulties in treatment engagement result if a therapist wrongly assumes that such a patient is convinced, as the therapist is, that: (a) the patient's coping responses are maladaptive and rooted in past conflicts, (b) their perceptions are cognitive distortions, and (c) that they are overreacting (or underreacting) with respect to present-day situations and likelihood of potential negative consequences (e.g., danger in trusting others).

Contemplation stage: Signs of stage-by-intervention mismatch. These include patients still resorting to old coping patterns (e.g., drinking, hypervigilance, isolation, anger outbursts) and inconsistent compliance with treatment plans despite a generally cooperative attitude. In addition, therapists may question patients' motivation or ability to change.*Contemplation stage:*

Assessment. Assessing a patient's readiness to change at this stage should include empathic discussion of the patient's view of where the problem comes from, and their view of their level of responsibility for changing the problem. Also, the patient should be asked what it would mean to admit the problem to other people.

Contemplation stage: Intervention. To help patients answer the question "Do I need to change?", therapists should focus on processes that facilitate making a decision that change is necessary. First, decision-balance techniques, in which patients weigh the pros and cons of changing a behavior or belief, help to clarify the advantages and disadvantages of maintaining or changing a behavior or attitude. For example, a patient who is unsure about the need to change the feeling of always wanting to be in control may list the pros or benefits to this behavior as "get things done quickly," "get things done my way," and "don't need to depend on others for input to make decisions." Cons or disadvantages may be "often make mistakes," "hurt others' feelings," "feel isolated," and "don't know how to ask for help."

Another useful technique is norm comparison, in which patients see where their behavior fits on a continuum from "average" to "extreme problem." Although this can be done informally, there are structured approaches. As practiced by Miller and colleagues (Miller & Rollnick, 2002), this can include using the results of medical or psychological tests, with the intervention being an objective, non-confrontational review of the how the patient's "numbers" compare with similar-age population norms and cutoff scores. Another technique is the "Comparison to the Average Guy" group module that is part of the PTSD ME Group (see following). In addition, therapist use of clear, understandable metaphors for problem origin and function can help clarify how the patient learned a particular behavior as a coping device, why it worked in past environments, and what makes the behavior maladaptive today (Newman, 1994). For example, we have often used the "getting in the house" metaphor, which describes a person who long ago could not get into a house that he needed to be in, and had to learn to get in by sneaking in the back door. Later in life, the person continues to use this method, never realizing that the front door is now unlocked. The goal of such interventions at this stage is for a patient to be convinced that they need to change maladaptive coping behaviors, that their response is an overreaction to current situations based on past negative situations or childhood environment, that their perceptions are distorted because of past events, and that advantages to change outweigh the disadvantages.

Preparation Stage

Once convinced of the need to change, individuals in Preparation stage frequently make initial steps toward addressing a particular problem. We feel that a key component of this stage is a person's uncertainty about the outcome of these change efforts (DiClemente, 1991), and so we propose that an important question in the mind of someone in Preparation stage is "I know I should change, but can I change?" In this stage, patient response to treatment can be negatively affected when treatment providers underestimate patients' confidence or self-efficacy about the ability to change. In addition, problems arise when a therapist mistakenly assumes that a patient understands how change occurs in therapy, feels capable of change, and feels participation will yield positive results. This can be a critical point for patients in that realizing the need to change but feeling one is incapable of change is a very discouraging or even depressing experience. In such a state, patients may question the need to change and thus regress to earlier stages of change (DiClemente, 1991).

Preparation stage: Signs of stage-by-intervention mismatch. These include relapse (to PTSD-based coping) and missed sessions after apparent therapy advances, reappearance of doubts about the need to change, depression, and anxiety about future progress.

Preparation stage: Assessment. To determine a patient's confidence in the ability to change it may be useful to allow that patient to rate self-efficacy in coping with situations related to the problem, behavior, or belief that the person has acknowledged the need to change. More informal discussion can focus on patient's beliefs that they can cope successfully, their understanding of how therapy works and what it involves, and the belief that using therapy tools will have beneficial effect, or be "worth it."

Preparation stage: Intervention. Therapists can best help patients answer the question "Can I change?" by spending some time in educating patients about how therapy works (Newman, 1994) and facilitating their participation in support groups. Allowing the patient to experience success in brief role-play or behavioral rehearsal tasks or periods of exposure to problem-related cues or situations also increases self-confidence in the ability to change. Related to the earlier discussion of practical roadblocks to initiating change, therapists should first recognize that these might

exist and not immediately blame problems in carrying out change on low motivation or resistance. Then, clinicians must coach patients in problem solving these external roadblocks (e.g., lack of finances, time, or energy, such as experienced by working single or even married, parents). Peer modeling is also most useful at this stage, as patients recognize the similarities between themselves and others with the same problems, and can gain encouragement, increased self-efficacy, and specific skills from observing these individuals. Therefore, maximizing patient involvement with more advanced or senior patients is critical at this stage. The goal of these efforts is to maximize self-confidence so that the patient can cope successfully and promote realistic but positive expectations of posttreatment recovery.

OTHER FACTORS THAT CAN RUIN PERFECTLY GOOD THERAPY FOR PTSD

Breakdown in the Therapeutic Relationship

As Miller and colleagues have emphasized, facilitating patient recognition of the need to change depends heavily on therapist behavior, specifically the use of an empathic, objective approach. Although somewhat beyond the scope of this chapter, we wish to at least briefly note the critical role that a strong therapeutic relationship plays in the success of any psychotherapeutic treatment, including PTSD treatment of combat vets. A strong therapeutic relationship or "working alliance" is best fostered by therapists using reflective techniques, resulting in patients feeling understood, listened to, and more willing to trust (Horvath & Luborsky, 1993; Miller, 1985). Numerous studies of psychotherapy suggest that therapist empathy and client report of the working alliance are the best predictors of patient outcome (Horvath & Symonds, 1991; Miller, et al., 1993). This approach may be critical for enhancing treatment adherence for combat veterans in treatment in PTSD.

What can disrupt or prevent the development of a good therapeutic relationship? Although PTSD patients can be mistrustful, argumentative, and uncooperative, this is often a direct manifestation of the problems for which they are in treatment (whether they realize it themselves or not). These instances should be seen as unique opportunities for forging a strong therapeutic alliance and not as signs of a patient resisting help or

the treatment not working (Newman, 1994). Meeting argumentativeness with reflective listening is often a surprising but powerful experience for patients, increasing their trust in the process of therapy and enhancing their willingness to explore unacknowledged problems or undertake therapeutic tasks. Therapists who argue with patients hoping to convince them of the right way to see the world or to see the negative consequences of their behavior lose this opportunity to gain patient trust and build the therapeutic relationship. Patients then become reluctant to engage in treatment, and treatment failure can result.

Race, Gender, and Social Class

Therapists must also be aware of issues related to race, gender, and social class that can hinder the development of a strong therapeutic relationship. Regarding race, racial differences between participants and leaders can elicit mistrust and bias that goes unaddressed. In addition, therapists must be sensitive to ethnic minority group members who have experienced lifelong exposure to racism, both obvious and subtle, and may be hesitant to engage in treatment in settings run by nonminority staff or populated by largely nonminority patients. It is the job of the therapist to not mistake this "cultural suspiciousness" for treatment resistance or even paranoia. Further, therapists must take into account cultural and ethnic differences in the expression or even the experience of strong emotion, which in some cultures feels like "going crazy."

A number of factors related to gender can influence patient response to treatment which therapists must consider. Although too numerous to enumerate here, these include male taboos about expressing feelings or appearing "weak," expectations for women to be passive and not express anger, and gender-specific attachment of shame for certain types of problems (e.g., alcoholism for women). In general, male-female power dynamics can arise in the therapeutic process and may need to be addressed during treatment.

With respect to social class, therapists must recognize differences in everyday language and vocabulary when working with patients from underprivileged or working-class backgrounds. We are often unaware of the extent of our use of psychology jargon in our work with patients, thus overestimating the degree of "psychological mindedness" among our patients. That is, the notion that emotions and perceptions are shaped by past events and affect current behavior. In addition, therapists may be

insensitive to class-related norms for anger, safety, emotional expressivity, and relationship/intimacy behaviors of patients from poor or working class environments.

AN EXAMPLE OF A STRUCTURED APPROACH TO MOTIVATING CHANGE IN PTSD PATIENTS

Applying a readiness to change model to PTSD symptomatology is still a new and developing area of treatment and research. This chapter offers a rationale for the potential clinical value of this approach in PTSD treatment and ideally will foster research on the role of problem awareness in PTSD treatment failure and the effectiveness of PTSD interventions based on the readiness to change model. We would like to end this chapter by describing a specific group intervention that has been designed to enhance motivation to change among combat veterans in PTSD treatment. The PTSD Motivation Enhancement Group is described in detail elsewhere (Murphy et al., in press) and will be briefly summarized here as an example of a structured treatment component aimed at preventing treatment failure from a readiness to change perspective.

The PTSD Motivation Enhancement Group

The PTSD ME Group, a manualized brief intervention, is conceptually based on the Stages of Change and utilizes Motivational Interviewing principles and techniques (Miller & Rollnick, 2002) that have been modified for group treatment of PTSD-related problems. The rationale for the PTSD ME Group is that increased recognition of the need to change specific PTSD symptoms and other problems will lead to better PTSD treatment adherence and outcome because patients will perceive coping skills learned in treatment as more personally relevant to their problems. As explained to the patients, the purpose of the group is to help them avoid being "blindsided" by unrecognized problems. For example, a patient who believes that social isolation is an acceptable coping strategy will likely withdraw from family or other social support under stress or after interpersonal conflict, which can lead to a downward spiral or sequence of other problems such as depression, hypervigilance, substance use, and reexperiencing symptoms. A patient who recognizes that social isolation is definitely a problem will be more likely to use adaptive coping

skills to address problems directly or use social support instead of withdrawing from others.

The PTSD ME Group protocol consists of four 90-minute sessions that focus on the use of decision-making skills to help patients recognize the need to change any unacknowledged PTSD-related problems. A key part of the group is having patients generate a list of behaviors or beliefs that might be a problem for them, called "Might Have" problems. These possible unrecognized problems are defined as problems they have wondered if they have, or problems that others have told them they have, but they disagree. Participants then use decision-making tools employed in the PTSD ME Group to help them decide if these "Might Have" problems are actually problems they definitely have. In the first PTSD ME Group session, "Rationale and Review," group leaders review the purpose, procedures, and potential value of the group. In the second session, "Pros & Cons," patients use decision balance techniques to determine the need to change specific behaviors or coping styles that they are unsure are problematic. The third session is called "Comparison to the Average Guy," in which patients compare their behavior to estimated age-appropriate norms to help them judge how problematic their behavior might be. For example, patients who are constantly hyperalert to danger but feel that this approach to daily life is appropriate are asked to compare their own behavior with safety-related behaviors that might be considered normative in terms of frequency (e.g., number of times checking locks at night), severity of consequences (e.g., impact on family), or purpose (e.g., caution vs. a sense of "life or death"). The fourth session, "Roadblocks," focuses on identification of individual cognitive and emotional factors (as described earlier) that may be preventing the patient from considering changing problematic behaviors. For example, veterans have often reported that fears of being perceived as weak, or shame about the distress they have brought to loved ones, will inhibit their willingness to admit or even think about a possible problem they have. Cognitive distortions that may be roadblocks include "all or nothing thinking" such as "If I admit to having one more problem, I will have to acknowledge being a complete failure."

Initial findings from an uncontrolled study of the effectiveness of the PTSD ME Group for 243 combat veteran participants have been encouraging (Murphy et al., in press). With respect to changes in problem awareness and ambivalence during the course of the group, veterans on average reclassified approximately 40% of all items they initially listed as "Might Have" to either "Definitely Have" or "Definitely Don't Have." For patients who classified various problems as "Might Have," by the end of

their participation in the group significantly more veterans reclassified the following problems as "Definitely Have" than "Definitely Don't Have": Anger, Isolation, Anxiety, Authority, Guilt, Emotional Masking, Relationship/Intimacy, Smoking, and Trust. Group participants reported high levels of satisfaction with all aspects of group content and process, and gave high ratings on perceived helpfulness (Franklin et al., 1999). Although conclusive statements about the effectiveness of the group await controlled trials, these initial findings indicate that patients are responding to the group as predicted. A randomized control study of the effectiveness of inclusion of the PTSD ME Group in a yearlong PTSD outpatient program is ongoing. The predictions are that participation in the intervention will result in increased recognition of PTSD-related problems, greater perceived relevance of treatment, increased engagement in the PTSD program treatment components (e.g., attendance rates and lower dropout over the year of treatment), and greater life satisfaction. Such findings would support the need for integrating a readiness to change approach into PTSD treatment programs in order to maximize patient benefit from treatment and prevent PTSD treatment failure.

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